Retired Employees Benefits Change Request Form – Province of Nova Scotia

NOVA SCOTIA
Public Service Commission

Instructions: To make changes to your coverage, **c**omplete, sign and date this form.

Return to : Benefits Unit, Nova Scotia Public Service Commission, P.O. Box 943, Halifax, NS B3J 2V9 **or** Benefits@novascotia.ca.

Section 1: Retiree Information

Last Name	First Name	Employee ID	Date of Birth (DD-MM-YYYY)

Section 2: Retired Employee Health Plan

Change coverage to:	Single ☐	Family ☐	Cancel Coverage ☐

Eligible Dependents

Spouse Last Name	Spouse First Name	Gender	Date of Birth DD/MM/YYYY	Date of Cohabitation if Common Law	Indicate `A' to add an individual; or `R' to remove
Child Last Name	**Child First Name**	**Gender**	**Date of Birth**	**Status***	

(*) Dependent Status:
Student - If dependent child is over age 21 and attending an accredited school, college or university an Overage Dependent Form is required Disabled - if the dependent child is physically or mentally disabled (Medavie Blue Cross approval required)
Grandchild - Required approval by the plan administrator - Proof of financial dependence is required for coverage of a grandchild

Section 3: Life Insurance

☐ I wish to REDUCE my Basic Life Insurance to $ _____ (use multiples of $1,000)

☐ I wish to REDUCE my Optional Life Insurance to $ _____ (use multiples of $1,000)

☐ I wish to CANCEL my Basic Life Insurance

☐ I wish to CANCEL my Optional Life Insurance

Section 4: Declaration and Authorization

Changes indicated above take effect on the date this form is received by the Benefits Unit, PSC.
Upon cancellation/reduction, I understand that I cannot reenroll in the Basic and/or Optional Life plans at a later date.
I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future may be collected, used or disclosed to administer the terms of my policy or the group policy of which I am eligible member, to recommend suitable products and services to me, and to manage the providers' business. I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent providers from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits consenting or refusing to consent to its disclosure. I certify that all information contained herein is correct and hereby authorize payroll deductions, if required. If applying for benefits for my spouse and/or dependents, I certify that I am authorized to release information concerning my spouse and/or dependents, for the purposes of administering and managing the benefit plan. A photocopy of this authorization shall be valid as the original.

Member's Signature:	Date: